



RESOURCE AND PATIENT MANAGEMENT SYSTEM

Electronic Dental Records

Installation and Implementation Guide

September 2013

Office of Information Technology
Division of Information Resource Management
Albuquerque, New Mexico

Table of Contents

1.0	Introduction.....	1
2.0	How to use this Guide.....	2
3.0	Pre-Installation Recommendations.....	3
3.1	Pre-Installation Meetings	4
3.2	Schedule.....	4
4.0	Post EDR Implementation Meetings	5
5.0	Recommendations for EDR use.....	6
5.1	Registration & Check In	6
6.0	Charting In EDR	8
6.1	Conditions whereby the Chart could be Eliminated	8
6.2	Oral Examination Charting Method.....	8
6.3	Skills Practice for Team Members	9
6.4	Colors for the Chart	9
6.5	Quick Buttons	9
6.6	Periodontal Charting.....	9
6.7	Ordering the Treatment Plan	10
6.8	Treatment Plans for Patients	10
6.9	Set Treatment Complete.....	10
6.10	Clinical Progress Notes	11
7.0	Scheduling.....	12
7.1	Eliminate the Paper Appointment Book	12
7.2	Eliminate Scheduling in both Dentrix and RPMS	12
7.3	Scheduling from the Treatment Plan	13
7.4	Pre-blocking.....	13
7.5	Walk-ins, Same day Appointments, and Emergencies	13
7.6	Broken Appointment Protocol	13
8.0	Reports.....	14
9.0	Retention of Patients.....	15
9.1	Hygiene	15
9.2	Incomplete Treatment.....	15
10.0	Insurance Billing.....	17
10.1	Advantages to Electronic Billing through Dentrix	17
10.2	Most Efficient Use of Electronic Billing through Dentrix	17
10.3	Tribal Sites using RPMS or other Third Party Billing Service.....	17
10.4	Federal Sites using RPMS for Billing.....	17
Appendix A:	Agenda Meetings.....	19

Appendix B: Expected Time Savings 23
Acronym List 24
Contact Information 25

1.0 Introduction

The purpose of this guide is to facilitate the implementation of the EDR (Electronic Dental Record) in an Indian Health Service (IHS) Dental Clinic. The guide is designed for use by an IHS Dental Clinic that is within four months of implementing the EDR.

The guide covers:

- Pre-installation recommendations
- Recommendations for use of the EDR

The benefits of using the guide prior to and during implementation of the EDR are:

- Access to knowledge gained from previous EDR implementations in IHS Dental Clinics
- Organized plan of action for implementation of EDR
- Recommendations to more quickly maximize the benefits of the EDR

2.0 How to use this Guide

The most important part of the EDR implementation is to have a plan and follow through with the plan. The clinics that are most fully utilizing the EDR are the clinics that have made changes to their business processes and fully utilize the features of the software. Using the following information, the dental chief can make the best decisions for his or her clinic whether that means adapting the current business processes or adapting the software to the clinic.

The larger the clinic, the more likely protocols are being done differently throughout to suit multiple providers. The software is most efficient when the entire clinic is utilizing it in the same manner and this means change. If all members of the dental staff are willing to approach the EDR with an open mind for making changes to existing processes, the benefits of the EDR can be fully maximized.

Included in this guide are suggestions of how and when to make the necessary changes for a successful implementation of the EDR. It takes commitment from all staff members to be successful.

3.0 Pre-Installation Recommendations

- The dental clinic should be open to emergency patients only during the initial EDR training.
- All dental, clerical, and support staff should be available for their scheduled training sessions.
- Integration with existing software such as digital radiography must be completed prior to training in order to avoid technology glitches at training.
- The IT department needs to confirm that all areas of technology work together prior to training so team members can get on the computers with live data immediately after training.
- The IT department should work with the EDR Installation Team to confirm if the existing digital radiography program will integrate with the new EDR.
- If team members need to learn how to import and export, or confirm they are taking radiographs in the correct patient chart, this should be addressed thoroughly at training.
- If the facility typically runs at a full capacity with patients in the chairs most of the day, consider cutting patient volume to 50% beginning with the first “go live” day, then moving towards a full schedule over a two- to four-week period.
- As reinforcement to training, when possible have two to three assistants work in a group while charting, scheduling, or checking out a patient after treatment. The three roles would be:
 - One to have hands on the computer
 - One to call out information
 - One to observeRotate the positions throughout the day until all assistants are comfortable with all aspects. This protocol should be followed until all clinical team members are comfortable with the new computer skills needed to enter data in the EDR. Most likely, two weeks will be sufficient.
- Discuss with the team exactly what will be done in the EDR and what, if anything, will still be done in the Resource and Patient Management System (RPMS). Examples would be:
 - No more clinical data entry will be needed in RPMS.
 - GPRA data will continue to be reported directly out of RPMS as it was prior to EDR.
 - Meaningful Use data will continue to come out of RPMS whether it is entered into the EDR or the Electronic Health Record (EHR).

3.1 Pre-Installation Meetings

Pre-installation meetings are key to an efficient and consistent implementation. Determine ahead of time which areas multiple providers may be executing protocols differently. Examples of such areas include:

- Scheduling
- Charting system
- Treatment planning
- Documentation
- Business processes

Make decisions in the above areas (or any other area where different methods are used) in order to achieve a uniform result.

3.2 Schedule

The first meeting should be scheduled three months prior to installation of the EDR. All team members and doctors should attend. The chief should facilitate the meeting. A recorder should be assigned to take notes.

- **Meeting 1** – Three months prior to installation
- **Meeting 2** – Two weeks later
- **Meeting 3** – One week later
- **Meeting 4** – Two weeks later

See Appendix A: for recommended agendas for each meeting

4.0 Post EDR Implementation Meetings

The team should have meetings after the EDR is implemented. Each team member will learn new things about the software as they are using it. They will also discover things they are doing that may be inefficient or ineffective. These team meetings allow for information to be shared so that everyone is learning together.

If possible, hook a projector up to a computer so everyone can see the same thing at once. As team members make discoveries using the EDR, both things that work and don't work, they need to make notes and bring them to the meeting to share that information.

Eventually the clinic could incorporate an agenda item in their existing staff meetings where EDR information can be shared on an ongoing basis.

5.0 Recommendations for EDR use

5.1 Registration & Check In

In most facilities, Registration is its own department with a staff that answers to supervisors other than the Dental Chief. However, there is overlap between Registration and the Dental Clinic which makes it important to work together to achieve the best result. Prior to implementation of the EDR, the Dental Chief should approach the Registration supervisor and begin open communication about the changes that will occur as a result of the EDR. Periodic meetings throughout implementation and beyond can minimize issues that may occur.

Facilities where patients check in with Dental Clinic first:

- If patients initially check in with the dental clinic, the status of the appointment would be changed to *arrived* and the patient would be called to registration. The patient's current medical and dental coverage would be gathered.
- During training, the clinic will be asked if they are going to file insurance electronically through Dentrix. If yes, the team will receive training to correctly enter dental insurance information into Dentrix.
- Once all information is entered properly and the patient can go to the clinical area, the status should be changed to *registered*. Do not take the patient to the clinical area until the status shows the patient as *registered*.

Facilities where patients check in with Registration first:

- For facilities where the patient checks in at main registration first, all patient and insurance information will be entered in RPMS by the Registration Department.
- The chief needs to determine how Registration will alert the Dental Clinic a patient has arrived and has been registered.
- The dental receptionist will then change the status of the appointment to "registered" which indicates to the clinical staff the patient is ready to be seated.

All facilities:

- Contact private pay insurance companies to verify eligibility. The verification of eligibility and benefits can be done on line or by phone. The on line method can save a lot of time if there are a significant number of patients that need to be verified.
- Once the patient information is updated, change the status of appointment to *registered* to let the clinical team know that the patient can be dismissed after treatment. If the status has not been changed to *registered*, the clinical team should ensure that the patient is returned to Registration to complete that process.

- If a patient gets called back to the clinical area prior to completing registration, the clinical team should bring the patient back to registration after the appointment.
- The Dental Chief should go through the entire check in and registration processes with everyone involved and clarify who will be changing the status and when.

For tribal facilities using eClaims through Dentrix:

- Prior to the patient going to the clinical area, the proper fee schedule must be assigned, i.e. Medicaid if applicable. All other info can be entered after the patient is seen in the clinical area.

6.0 Charting In EDR

Consider eliminating the use of the paper chart and use the EDR exclusively for clinical charting, treatment planning, and progress notes.

6.1 Conditions whereby the Chart could be Eliminated

- There is no medical within the facility therefore no medical chart
- The facility consistently uses the EHR and updates necessary information
- There is no required information for the Dental Clinic to enter into the medical chart
- Where there is an approved electronic method to record patient signatures for consent, treatment plans, etc.

Having the doctor call out several previous treatment plans and allow the team members to practice real data entry is a great way to enhance everyone's skills, gain speed, and have the doctors comfortable with the strategic way to call out treatment to achieve the most efficiency.

Consider entering previous procedures and conditions in to Dentrix to complete the dental chart history. This eliminates the need of the paper chart to see the dental history. An efficient method to convert the data is for the staff to divide the charts of the patients coming in the next day for appointments. When there is time throughout the day, enter the existing conditions and procedures for those patients. Then when they arrive the next day for their appointment, the dental history is already updated. This will only work as well as the quality of the data that was recorded in the past. Remember, in EDR/Dentrix, restorations can only be recorded if the appropriate surfaces (i.e. MODBL, class V) are known

The chief needs to work closely with Medical Records to confirm this protocol so charts can be made available to the dental clinic staff.

6.2 Oral Examination Charting Method

The order for the dentist to call out information would be:

- Tooth #
- Procedure
- Surfaces
- Status

This matches the order the team member will need to click the information. All procedures of a certain status should be charted together, for example, all existing procedures followed by all treatment planned procedures.

The most efficient charting method is to click the “+” button on the Status Bar, changing it to “-”, thus allowing the user to lock the status so it does not need to be clicked every time. This is called the Autostate button.

The Autostate button is not trained in the initial sessions as it is considered an advanced feature. It will be trained at the second session of training, four to six weeks after the initial session. Once the team has been trained to use the Autostate button, use it for charting.

6.3 Skills Practice for Team Members

- Staff members can enter the treatment plans for patients that have scheduled appointments.
- Staff members can enter existing procedures and conditions for patients that have scheduled appointments.

6.4 Colors for the Chart

The colors for the chart are pre-determined by Indian Health Service and should not be altered. Refer to the Dentrix Enterprise Training Manual for chart colors.

All entries in the Progress Notes must be in black. This is a setting that must be selected in the chart.

6.5 Quick Buttons

Most of the Quick Buttons for charting are pre-determined by IHS. There are three Quick Buttons available for customization by the clinic. These should be the same in each operatory. An exception would be if the clinic has certain operatories where only pedo or endo (or any other specialty) is seen. These Quick Buttons could be customized for that specialty.

6.6 Periodontal Charting

The recommended order for periodontal charting is:

- Begin on the buccal surface of tooth #1 and move across the buccal surfaces of all maxillary teeth to the buccal surface of tooth #16.
- Go to the lingual surface of tooth #16 and move across the lingual of the maxillary teeth to the lingual surface of tooth #1.

- Go to the buccal surface of tooth #32 and move across the buccal surface of the mandibular teeth to the buccal surface of tooth #17.
- Go to the lingual surface of tooth # 17 and move across the lingual surfaces of the mandibular teeth to tooth #32.

6.7 Ordering the Treatment Plan

The doctor should dictate to the assistant how to group the treatment and the prioritization of the treatment. The doctor can confirm the accuracy of the treatment plan entered before leaving the treatment room.

If the staff did not get the level of training to know how to prioritize in the initial training, then ask for it in the follow up training session. It is important for the patient to see how the treatment plan will be delivered as it helps build value for the appointments, thus helping to reduce no shows.

6.8 Treatment Plans for Patients

- The provider should print a copy of the treatment plan for the patient:
 - Builds value for the appointments.
 - Reduces no show and broken appointments.
 - Gives the patient a visual representation of treatment needed.
- Printers should be located in the clinical area.
- The doctor or assistant should to review the treatment plan with the patient.
- Treatment plans should be printed on a color printer so the patient can clearly see the treatment needed in a different color.

6.9 Set Treatment Complete

Use the blue check mark.

At the end of each appointment, the clinical team is responsible to **set complete** the treatment done on that day's visit. Always verify that the procedure was treatment planned first before setting it to complete.

- If the treatment performed is already part of the treatment plan, **set complete** for that procedure from the treatment plan.
- If the treatment is not part of the treatment plan, it needs to be entered with a status of Complete.

6.10 Clinical Progress Notes

Use the IHS template progress notes as a starting point. The IHS templates can be modified or you can develop a progress note template *from scratch* to meet your clinic's needs. The reasons to use template notes are:

- Increased efficiency
- Decreased error
- All necessary data is always entered
- Uniformity for chart reviews

The dentist should enter narrative type information in addition to the clinical notes in case it is needed later for insurance claims. This provides efficiency because the insurance department will not have to send the claim back to the dentist for further information, it is already there.

7.0 Scheduling

Implement one scheduling model to be used by all providers. The pre-installation meeting to determine the schedule model is critical to the most effective result of using the EDR.

Potential scheduling models:

- By clinic – columns are defined by type of dentistry or specialty
- By provider – columns are defined by provider
- By chair – columns are defined by the operator (i.e. each column is assigned an operator)

7.1 Eliminate the Paper Appointment Book

It is a struggle for some team members and some doctors to give up the paper scheduling book. The Dentrix trainer will make every effort to have the appointment book converted by the *Go Live* date.

The reasons for eliminating the paper appointment book are:

- There are more risks for error when writing the appointment in several places in addition to entering it into the computer.
- It eliminates duplicate work.
- Because making the appointment in the EDR is the newest method and the least familiar at first, it usually gets left until last, risking that the appointment is never entered in the EDR.

7.2 Eliminate Scheduling in both Dentrix and RPMS

There are three reasons the clinic might still want to enter appointments into RPMS:

1. Appointment reminder letters
2. As a place holder in the RPMS Patient Scheduler to help prevent the double booking of medical and dental appointments
3. Charts to be pulled

If clinics implement the following, it would eliminate the need to enter the appointments into RPMS:

- Training for the team to use letter merge in order to send letters to patients with a scheduled appointment. This eliminates the need to enter appointments into RPMS to generate these reminders. (Minimal training on letter merge is covered at the initial training, then more in depth at follow up training)

- An appointment book view with chart numbers can be generated and given daily to the Medical Records department and charts can be pulled from this list. The Dental Chief should meet with the Medical Records Supervisor to review the process so that Medical Records understands that this request is critical enough that the Chief wanted to ensure it went smoothly.
- The staff is trained how to create and print the above appointment book view at initial training.

7.3 Scheduling from the Treatment Plan

When appointments are created, the team should schedule from the treatment plan versus entering a generic description. This provides more detail in the scheduler so assistants can properly setup operatories. It also allows the status to be updated from treatment planned to complete once the treatment is set complete. It is still possible to add or change procedures if needed once the patient arrives for that appointment.

7.4 Pre-blocking

Consider pre-blocking the schedule if the schedule includes certain times where specific procedures or types of patients (diabetic, pregnant) should be scheduled. Pre-blocking can help create a visual for the team to know where those procedures or types of patients need to be placed into the schedule. This does not mean that every single hour is pre-blocked. If the entire column is pre-blocked with specific appointment types, it can be too rigid to be practical for scheduling.

All team members need to understand what the pre- blocks stand for and honor them.

7.5 Walk-ins, Same day Appointments, and Emergencies

Use a single column and list walk-ins in the order they arrive. Once the clinic has determined which provider is going to see the patient, click and drag that patient's appointment to the correct column for that provider. Then double click the appointment and change to the provider that will be seeing the patient.

An alternate method is to create a "dummy" provider named **Dr. Walk-In** for all walk-in patients. This allows for patients that leave without being seen to be recorded (for Dr. Walk-in) without affecting the statistics (e.g., broken or cancelled appointments) for real providers.

7.6 Broken Appointment Protocol

Refer to the Dentrix Enterprise Training Manual for the correct protocol to follow for broken appointments, no show appointments, and use of the waiting list (if used at your facility).

8.0 Reports

Learn the new reports that are available through the EDR. Some are duplicate reports from RPMS because there is certain information the Indian Health Service requires its clinics to provide. There are also new reports available that allow the chief and the dentists to monitor other information. These can be helpful in ascertaining the efficiency and effectiveness of the dental program.

There are daily, weekly, and monthly reports that are recommended for various purposes and team members in the clinic. Some reports are for other departments that handle something related to the dental clinic. Others in the facility should know and understand the EDR reports that make their job more efficient. These other people in the facility having an understanding of that part of the EDR will also aid in more clear communication.

Reports that would still come from RPMS

- Insurance aging
- If filing electronically, need report that shows additional information needed
- Electronic attachments – the small investment per claim will return multifold in faster payment and decreased follow up and stress. Use radiographs, intra-oral images, periodontal chartings

For a list of specific reports, a description of each report and how to generate the report, refer to the IHS Report Guide.

9.0 Retention of Patients

The EDR provides easy to use features that allow the staff to follow up with overdue patients. The chief should review the waiting list for the clinic:

- If there is little to no waiting list for initial exams and a patient can get an appointment within seven days, the enhanced recommendation may be a possibility for the clinic.
- If the waiting list is over two weeks, the basic recommendation will most likely apply.

9.1 Hygiene

Basic Recommendation:

- On the first of the month, send a post card to patients due in the next month.
- No further follow up from the clinic.
- Generate the post cards through the letter merge of Dentrix.

Enhanced Recommendation:

- On the first of the month, send a post card to the patients due in the next month.
- Generate the post cards through the letter merge of Dentrix.
- The second week of the month, generate a Continuing Care list from Dentrix of the patients that received the post card. (patients that have scheduled will not be on this list).
- Begin making calls to patients from the list.
- Make two calls one month apart.
- Every six months, up to two years, continue to send a reminder post card, generated through the letter merge of Dentrix, to patients that have not scheduled for recall.
- Team members should document any patient contact in the Office Journal for tracking and information purposes.

9.2 Incomplete Treatment

Basic Recommendation:

- On the first of the month, send a post card to patients with incomplete treatment in the past month.
- No further follow up from the clinic.
- Generate the post cards through the letter merge of Dentrix.

Enhanced Recommendation:

- On the first of the month, send a post card to the patients with incomplete treatment in the past month.
- Generate the post cards through the letter merge of Dentrix.
- The second week of the month, generate the Unscheduled Treatment report for the same date range used for the post cards.
- Make calls to patients who received the post card and have not yet scheduled.
- Make two calls one month apart.
- Team members should document any patient contact in the Office Journal for tracking and information purposes.

10.0 Insurance Billing

10.1 Advantages to Electronic Billing through Dentrix

- More efficient
- Greater accuracy
- Less chance for human error
- Claims paid faster, typically less than 30 days (see Appendix B for time saving data)
- Less time required for follow up on unpaid claim
- Significant Increase in Private Pay collection

10.2 Most Efficient Use of Electronic Billing through Dentrix

- Create and send claims daily
- Confirm appropriate narratives are on the claims that need additional information
- Print and review Validation report from eClaims service:
 - List of claims sent
 - Number of claims
 - Dollar amount of claims
- Print and review Transmission report from eClaims service:
 - Number of claims accepted (all necessary information received)
 - Number of claims rejected (more information needed)
 - Transmission report reflecting if any claims had to be printed to paper

10.3 Tribal Sites using RPMS or other Third Party Billing Service

- Can continue as they are
- Can change to electronic billing through Dentrix
- Contact Dentrix or speak with Dentrix trainer

10.4 Federal Sites using RPMS for Billing

- No change is required

- However, if the chief is interested in changing to electronic claim filing through Dentrix, contact Dr. Jim Schaeffer at James.Schaeffer@ihs.gov or 301-443-4319.

Appendix A: Agenda Meetings

A.1 Agenda Meeting 1

When: Three Months before scheduled implementation

Who: Entire Team including IT Staff

A.1.1 What is EDR?

Electronic Dental Record – Just like all of the patient’s medical information is being or has been converted to the Electronic Health Record, the EDR will decrease the use of or eliminate the dental chart. Patient information will be accessible via computer. Charting, treatment planning, patient appointments, notes, and patient personal information will all be accessed in the computer from any workstation rather than having the hard chart.

A.1.2 What are the benefits of EDR?

- Patient’s electronic record is available to all team members at all times
- Increases efficiency by eliminating the need to look for charts
- Enhances patient care by increasing efficiency
- Creates value and motivation for the patient to complete treatment
- Digital x-ray motivates patients to return for treatment
- Electronic charting provides efficiency and accuracy in scheduling and treatment planning
- Decreased stress from lost records, illegible data, and waiting for charts
- Templates for progress notes allow data entry at the point of service rather than stacks of charts at the end of the day
- Increases accuracy in coding of procedures due to the presence of accurate ADA codes in the software.
- Increase access to care by increasing efficiency throughout the clinic
- All providers schedules will be available to all team members at the same time
- Option available to file dental claims electronically, thereby increasing collection rate and decreasing the age of accounts.

A.1.3 Training Schedule

- There will be training scheduled.
- Describe the patient schedule during the week of training. The clinic will be seeing emergency patients only to assess the patient concern and reappoint for treatment. Palliative only treatment will be rendered as necessary.
- Tell team there will be hands on training to give confidence and decrease fear.
- Be clear about the amount of training each person will receive. There was a misperception in the larger facilities when the team heard they would receive a week of training. They thought it meant a week per person, not a week for the whole clinic.
- The trainer will remain at the clinic for the two *go live* days following initial training to assist the dental staff and answer questions.
- Two days of follow up training will occur approximately three to four weeks following the *go live*. Team members will be expected to have questions for the trainers to address during the follow up training.

A.1.4 Support

- There will be an Indian Health Services specific support line at the Dentrix Help Desk available to all team members for questions about the EDR.
- It is expected that team members support each other during the implementation and training process.
- Q & A

A.1.5 Assignment for Next Meeting Two Weeks from Today

- Doctors – bring an example of each person’s own ideal scheduling model
- Hygienists – bring an example of each person’s own ideal scheduling model
- Chief Dental Officer – identify one member of dental staff and one member of IT staff as the Local EDR Implementation Team and work directly with the National EDR Implementation Team.

<p>Note: The Local EDR Implementation Team needs to begin to address the Corrective Actions identified in the EDR Site Assessment.</p>

A.2 Agenda Meeting 2

When: Two Weeks Later

Who: Dentists & Hygienists

- Determine one scheduling model or master schedule to be used by the entire clinic. See Section 7.0 for guidance in making these decisions.
- All providers bring their ideal scheduling model (the way they like their day to flow).
- Find the commonalities among the different scheduling models.
- The chief will facilitate discussion to agree on common scheduling model. Clinics that convert to one scheduling model are more efficient and effective.
- Assignment: Begin using new scheduling model now.
- By discussing the different scheduling models and implementing a more common approach, increased efficiency in scheduling will be achieved. (Example: if clinic was scheduling chairside, this would allow for scheduling to be done at the business office, thus taking that responsibility off the clinical team and allowing them to focus on clinical care.)
- Local EDR Implementation Team report on the progress of addressing the Corrective Actions identified in the EDR Site Assessment.
- Continue to address outstanding Corrective Actions.

A.3 Agenda Meeting 3

When: One Week Later

Who: Dentists, Hygienists, Any team member that schedules

- Introduce agreed upon scheduling model to all team members that schedule.
- Clarification of questions regarding implementation.
- The clinic should determine if existing procedures and conditions will be entered into Dentrix.
- Local EDR Implementation Team report on the progress of addressing the Corrective Actions identified in the EDR Site Assessment. Continue to address outstanding Corrective Actions. Assignment for next meeting (in two weeks)
 - Dentists – bring examples of clinical notes templates and commonly prescribed medications (including dosage and instructions for each).
 - Dental Hygienists – bring examples of clinical notes templates.

A.4 Agenda Meeting 4

When: Two Weeks Later

Who: Dentists, Hygienists, Any team member that schedules

- Review how the new scheduling model is working.
- Finalize scheduling model for clinic.
- Review and finalize clinical notes templates for commonly performed procedures.
- Determine list of commonly prescribed medications and normal dosage and instructions. These will be entered during setup of software to provide a drop down list of meds, therefore eliminating hand written prescriptions and eliminating the doctor having to populate every field of information each time an RX is given.
- Local EDR Implementation Team report on the progress of addressing the Corrective Actions identified in the EDR Site Assessment. Continue to address outstanding Corrective Actions.

Appendix B: Expected Time Savings

In a small federal clinic location before filing the private insurance claims electronically most of these claims were 90 to 120+ days past due. The insurance coordinator was making about 20 to 25 calls per week trying to get these claims paid. The range of time she would be on hold with an insurance company was 15-30 minutes.

Now, with electronic filing of insurance claims for these private insurance patients this clinic has most of their claims paid within 30 days with a few paid within 60 days. In addition, the calls have dropped from 20 to 25 calls per week trying to get these claims paid to five or less calls per week. What this equates to in saved time for this small location is:

- $20 \text{ calls per week} \times 15 \text{ minutes} = 300 \text{ minutes}$
- $300 \text{ minutes} \div 60 \text{ minutes} = 5 \text{ hours per week}$
- $5 \text{ hours per week} \times 4 \text{ weeks per month} = 20 \text{ hours per month}$

Now with calls @ five or less calls per week:

- $5 \text{ calls per week} \times 15 \text{ minutes} = 75 \text{ minutes}$
- $75 \text{ minutes} \div 60 \text{ minutes} = 1\frac{1}{4} \text{ hours per week}$
- $1\frac{1}{4} \text{ hours per week} \times 4 \text{ weeks per month} = 5 \text{ hours per month}$

Time saved: 15 hours per month in a small facility.

In addition to the time savings the private insurance payments are now paid two to three months earlier, increasing revenues as well!

Acronym List

EDR	Electronic Dental Record
EHR	Electronic Health Record
IHS	Indian Health Service
RPMS	Resource and Patient Management System

Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT Help Desk (IHS).

Phone: (505) 248-4371 or (888) 830-7280 (toll free)

Fax: (505) 248-4363

Web: <http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm>

Email: support@ihs.gov